Complete Summary

GUIDELINE TITLE

U.K. guidelines for the management of cutaneous melanoma.

BIBLIOGRAPHIC SOURCE(S)

Roberts DL, Anstey AV, Barlow RJ, Cox NH, Newton Bishop JA, Corrie PG, Evans J, Gore ME, Hall PN, Kirkham N. U.K. guidelines for the management of cutaneous melanoma. Br J Dermatol 2002 Jan;146(1):7-17. [60 references] PubMed

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Cutaneous melanoma

GUIDELINE CATEGORY

Diagnosis
Management
Prevention
Treatment

CLINICAL SPECIALTY

Dermatology
Family Practice

Internal Medicine
Oncology
Plastic Surgery
Radiation Oncology
Surgery

INTENDED USERS

Physicians

GUIDELINE OBJECTIVE(S)

To provide best practice recommendations for the management of patients with cutaneous melanoma

TARGET POPULATION

Patients with cutaneous melanoma

INTERVENTIONS AND PRACTICES CONSIDERED

Prevention and Screening/Surveillance

1. Limitation of sun exposure
2. Lesion removal
3. Referral to specialists
4. Risk assessment and referral for genetics counseling
5. Counseling on self-examination for changing naevi
6. Monitoring of high-risk individuals for malignant changes

Clinical Assessment

1. Full skin examination
2. Photographic record of lesions
3. Examination for lymphadenopathy and hepatomegaly
4. Biopsy of suspected melanoma (Note: shave or punch biopsies are not recommended)
5. Histopathological tissue assessment
6. Fine needle aspiration cytology (FNAC) of lymph nodes
7. Staging investigations for patients at intermediate or high risk of recurrent disease (stage IIB and above)
    - Chest x-ray
    - Liver ultrasound
    - Computed tomography (CT) scan
    - Liver function tests
    - Lactate dehydrogenase
    - Full blood count
    - Bone scan (when symptoms point to possible bone disease)

Treatment

1. Surgical excision, with surgical margins based on Breslow thickness
2. Block/radical dissection of regional lymph nodes
3. Isolated limb perfusion/limb infusion with cytotoxic agents
4. Carbon dioxide laser ablation
5. Radiotherapy
6. Chemotherapy
    - Dacarbazine
7. Adjuvant therapy
    - Enrollment in clinical trials

Follow-Up

1. Patient self examination
2. Physician visits
3. Continued or future pregnancy counseling

Interventions Considered But Not Recommended

Interferon adjuvant therapy, adjuvant vaccines, sentinel lymph node biopsy, gene testing

MAJOR OUTCOMES CONSIDERED

- Risk assessment
- Side effects of therapy
- Survival
- Disease recurrence
- Disease remission

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

Not stated

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Weighting According to a Rating Scheme (Scheme Given)

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Levels of Evidence*

Ia: Evidence obtained from meta-analysis of randomized controlled trials

Ib: Evidence obtained from at least one randomized controlled trial

IIa: Evidence obtained from at least one well-designed controlled study without randomization

IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

*Note: Due to the process of producing unified guidelines, the quality of evidence grading used in these guidelines differs slightly from that used in other British Association of Dermatologists current guidelines.

METHODS USED TO ANALYZE THE EVIDENCE

Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

Not stated

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Recommendation Grades

A. There is good evidence to support the use of the procedure.
B. There is fair evidence to support the use of the procedure.
C. There is poor evidence to support the use of the procedure.
D. There is fair evidence to support the rejection of the use of the procedure.
E. There is good evidence to support the rejection of the use of the procedure.

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

Internal Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

Draft guidelines are edited by the Therapy Guidelines and Audit Sub-committee (TGA) and subsequently returned to the task force for revision. The approved draft version is published in the quarterly British Association of Dermatologists (BAD) newsletter, and all BAD members are given the opportunity to respond, positively or negatively, but hopefully helpfully, within three months of publication. Finalised guidelines are approved by the TGA and the Executive Committee of the BAD and finally published in the British Journal of Dermatology.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

The levels of evidence (I-IV) and strength of recommendation ratings (A-E) are defined at the end of the "Major Recommendations" field.

Prevention of Melanoma

Individuals, and particularly children, should not get sunburnt (Level of evidence III). White-skinned individuals should limit their total cumulative sun exposure through life. Lesions that are not obviously benign, or changing moles, should be seen by family doctors and either removed in their entirety for pathological examination, or referred and dealt with by appropriately trained specialists (III).

Clinical Diagnosis of Melanoma

The seven-point checklist emphasizing a history of change in size, shape, and colour of a pre-existing pigmented lesion is recommended for use for both patient and general practitioner education.

Major features are:

- Change in size
- Irregular shape
- Irregular colour

Minor features are:

- Largest diameter 7 mm or more
- Inflammation
- Oozing

- Change in sensation

Lesions with any of the major features or three minor ones are suspicious of melanoma. Suspicious lesions should ideally be seen by specialists, that is, clinicians routinely treating large numbers of patients with pigmented lesions. Where suspicious lesions are biopsied they should be removed completely and sent for histopathological examination.

Referral

Recommendations for Referral

- Patients with lesions suspicious of melanoma should be referred urgently to a dermatologist or surgeon/plastic surgeon with an interest in pigmented lesions.
- These specialists should ensure that a system is in place to enable patients with suspicious lesions to be seen within 2 weeks of receipt of the referral letter.
- All patients who have had lesions removed by their general practitioner that are subsequently reported as melanoma should be referred immediately to specialists.

(Grade of recommendation C, III)

Initial Assessment and Management

Any patient with a pigmented lesion that the specialist feels is clinically suspicious of melanoma should have a full skin examination. The site and size of the pigmented lesion should be documented and a record should be made of other pigmented lesions. Clinical photographs may be helpful. The patient should be carefully examined for lymphadenopathy and hepatomegaly.

Recommendations for Record Keeping of Clinical Features

As a minimum, the following should be included:

- History (the presence or absence of these changes should be recorded):
    - Change in size
    - Change in colour
    - Change in shape
    - Symptoms (itching, bleeding, etc.)
- Examination
    - Site
    - Size
    - Description (noting irregular margins, irregular pigmentation, and ulceration, if present)
    - Other pigmented lesions
    - Any regional lymphadenopathy
    - Examination for hepatomegaly

(B, III)

Recommendations for Screening and Surveillance of High-Risk Individuals

- Patients who have already had a melanoma or who have the atypical mole syndrome are at moderately increased risk of another primary, and should be advised of this and taught how to recognize a melanoma.
- Patients with giant congenital pigmented naevi are at increased risk of melanoma and require long-term follow-up.
- The prophylactic excision of small congenital naevi is not recommended.
- Individuals with a family history of three or more cases of melanoma should be referred to a Department of Clinical Genetics for counselling. Those with two cases in the family may also benefit, especially if one of the cases had multiple primary melanomas or the atypical mole syndrome.

(B, IIa)

This group of particularly high-risk individuals should be advised on the specific changes that suggest melanoma and encouraged to undertake monthly self examination (III). Photography may be a useful adjunct to detecting early melanoma in either of these high-risk groups (III)

Biopsy of Suspected Melanoma

Excision of a lesion suspected to be melanoma should be performed as a full-thickness skin biopsy to include the whole tumour with a 2-5-mm clinical margin of normal skin laterally and with a cuff of subdermal fat. This allows confirmation of the diagnosis, such that subsequent definitive treatment can be based on Breslow thickness.

Shave and punch biopsies are not recommended because they will at the very least make the pathological staging of the lesion impossible (III). Incisional biopsy is occasionally acceptable, for example in the differential diagnosis of lentigo maligna on the face or of acral melanoma, but there is no place for incisional biopsy in primary care (III). There is little evidence that incisional biopsies of melanoma affect the prognosis, although one paper suggests that there may be an adverse effect in lesions situated on the head and neck.

Biopsies of possible subungual melanomas should be carried out by surgeons regularly doing such biopsies. The nail should be removed and clinically obvious tumour or, in the absence of a mass, the nail matrix should be adequately sampled.

Prophylactic excision of pigmented lesions or of small congenital naevi in the absence of suspicious features is futile and not to be recommended.

Histopathology

Recommendations for the reporting of tissues removed as part of the surgical treatment of cutaneous melanoma have been published in an international consensus statement supplemented by a proposed final revised staging system for cutaneous melanoma published recently. Table 2 in the original guideline

document gives the recommended American Joint Committee on Cancer staging system.

Pathology request forms must be accurately completed and give full identification details. The whole lesion should be adequately sampled, probably by serial transverse slicing of the biopsy at approximately 2-mm intervals, processing all of the slices, and examining sections cut at three levels. The pathologist's report should include the following minimum data:

- The site of the tumour
- The type of surgical procedure: excision or re-excision, incision biopsy, punch biopsy, shave biopsy, curettage, other
- A full description of the macroscopic appearance of the tumour and the dimensions of the specimen in millimetres
- When possible, a statement of whether the lesion is primary, locally recurrent, or metastatic to the site.
- Whether there is ulceration
- The Breslow thickness of the tumour, measured from the granular layer of the epidermis to the base of the tumour, to the nearest 0.1 mm. Ulcerated tumours should be measured from the base of the ulcer to the base of the tumour. Tumour forming a sheath around appendages should be excluded when making measurements.
- The depth of penetration of the dermis (Clark's level) may also be stated, although this is a less reliable indicator of prognosis than Breslow thickness in most circumstances.
- The presence of radial growth phase tumour alone or vertical growth phase
- The frequency of mitotic figures/mm^2 (vertical growth phase only).
- The presence or absence of tumour regression
- The presence (and, if present, the degree) or absence of a lymphocytic inflammatory infiltrate in, or in response to, the tumour (II)
- The presence of any obvious lymphatic or vascular invasion or perineural invasion
- The histogenetic type of melanoma, including the presence of desmoplasia and/or neurotropism
- The presence of microsatellites
- Whether excision is complete and the minimum margin of excision to peripheral or deep surgical margin, measured in millimetres. If excision is not complete, the residual disease should be identified as in situ or invasive.
- Pathological staging (primary tumour, regional lymph nodes, distant metastasis [TNM] classification) and coding (e.g., SNOMED code).

Definitive Treatment for the Primary Lesion

Surgical excision margins for invasive melanoma depend on the Breslow thickness as measured by the histopathologist and are based on two randomized clinical trials and a National Institutes of Health Consensus Panel. The recommended surgical margins are those measured clinically at the time of surgery, rather than the histopathological margins measured microscopically. The margins suggested may need to be adjusted for cosmetic or functional reasons, for example, around the eye.

Recommended Surgical Excision Margins

Breslow Thickness	Excision Margins	Approximate 5-year Survival	Grading of Evidence
In situ	2-5-mm clinical margins to achieve complete histological excision	95-100%*	B, III
Less than 1 mm	1 cm (narrower margins are probably safe in lesions less than 0.75 mm in depth)	95-100%	A, I
1-2 mm	1-2 cm	80-96%	A, I
2.1-4 mm	2-3 cm (2 cm preferred)	60-75%	A, I
Greater than 4 mm	2-3 cm	50%	B, III

*In theory recurrence should never occur after in situ melanoma, but occasional cases do recur. The assumption is that regression at diagnosis obscured a more advanced tumour or that progression occurred after incomplete removal of the in situ disease.

Investigations for Patients with Melanoma

No investigations are necessary for patients with stage I disease. Stage I and IIA melanoma patients should not be staged by imaging, as the true-positive pick-up rate is low and the false-positive rate is high.

Patients at intermediate or high risk of recurrent disease (stage IIB and over) should have the following staging investigations: chest x-ray; liver ultrasound or computed tomographic (CT) scan with contrast of chest, abdomen ± pelvis; liver function tests/lactate dehydrogenase; and full blood count. In the absence of effective chemotherapy for melanoma, however, it may be reasonable to omit scanning in individual stage IIB patients. There is no place for a bone scan in staging except where symptoms point to possible bone disease.

Recommendations for Investigations

- Stage I and IIA melanoma patients should not be staged by imaging as the true-positive pick-up rate is low and the false-positive rate is high. This recommendation would be revised if effective therapy for visceral melanoma were identified (A, II).
- Stage IIB and over patients should be referred to a Cancer Centre service for consideration of trials of adjuvant therapies.

Adjuvant Therapy

There are no adjuvant therapies of proven benefit for melanoma as yet, but several clinical trials are actively recruiting patients. Patients at intermediate or high risk of relapse should be referred to the multidisciplinary team based at a Cancer Centre, staged (see investigations list above; these may vary according to study protocol), and considered for a trial of adjuvant therapy without delay (stages IIB, IIC, or III). Most trials require entry within 8 weeks of completion of surgery and therefore this referral to the Cancer Centre should be prompt.

Patients should be offered entry into clinical trials wherever possible. This is particularly important in the context of adjuvant therapy. Clinicians involved in the care of patients with melanoma should regularly update themselves on the clinical trials available to their patients. This can be done through the local Cancer Centre or the Melanoma Group of the National Cancer Research Institute. Entry criteria vary but, in general, those with stage IIB or stage III disease can be considered, although this may change with time.

Adjuvant therapies should be delivered by specialists.

The role of vaccines as adjuvant therapies remains to be established.

There is no role for adjuvant isolated limb perfusion (ILP) (Ib), although it may have a role in preoperative reduction of tumour volume.

Recommendation for Adjuvant Therapy

The role of interferon as an adjuvant therapy remains to be established (C, I).

Management of Clinically Node-Negative Patients

Recommendations for Management of Clinically Node-Negative Patients

There is no role for elective lymph node dissection (E, I).

Sentinel node biopsy can be used for staging in stage II melanoma in specialist centres in clinical trials, but unless evidence emerges for a role in determining outcome, it should not be routine (C, IIa).

Management of Patients with Clinically or Radiologically Suspicious Lymph Nodes

Fine needle aspiration cytology (FNAC) of nodes is recommended when there is clinical doubt about the significance of the nodes. This may need to be repeated if there is a negative result but on-going suspicion. Open biopsy is recommended when there is clinical suspicion even in the presence of negative FNACs in which lymphocytes have been successfully aspirated. If open biopsy is performed, the incision must be such as to allow subsequent complete formal block dissection of the regional nodes without compromise.

Management of Patients with Confirmed Positive Lymph Node Metastasis

Radical lymph node dissections should be performed by those with expertise in the surgery of this condition. Prior to block dissection, staging investigations should be carried out as listed previously. Imaging of the liver by either CT scan or ultrasound should be performed preoperatively. Where preoperative scanning would necessitate delay to surgery that is considered necessary even if widespread disease were to be detected, postoperative scanning may be carried out. The decision as to whether or not surgery should proceed prior to scanning should be made after careful discussion with an informed patient.

The management of regional lymph node metastases is as follows:

- If only one or two involved nodes are present below the inguinal ligament, a subinguinal node dissection of the femoral triangle is indicated.
- If there is gross involvement of the subinguinal nodes, or if the node of Cloquet is involved, then some would recommend extended dissection to include the iliac and obturator nodes to prevent local recurrence (III).
- Where relapse involves further lymph node basins, these should be treated by block dissection. In the neck, a functional dissection is ideally performed, although in more locally advanced disease a radical neck dissection may be appropriate.
- A block dissection specimen should be marked and orientated for the pathologist. The pathologist should be asked to report on the number of nodes in the specimen and the presence of any extracapsular spread.

Locoregional Recurrent Melanoma: Skin and Soft Tissues

Where possible in the case of single local or regional metastases, surgery is the treatment of choice. Patients with multiple local metastases in a limb should be referred to a center specializing in regional therapy where the following may be considered: ILP or limb infusion with cytotoxic agents; and carbon dioxide laser ablation for multiple small superficial lesions (III). Radiotherapy is not recommended in the first instance (III).

Recommendations for Locoregional Recurrent Melanoma

- Nodes clinically suspicious of melanoma should be sampled using fine needle aspiration cytology (FNAC) prior to carrying out formal block dissection. If FNAC is negative although lymphocytes were seen, an open biopsy should be performed if suspicion remains (B, III).
- Prior to formal dissection, performed by an expert, staging by scan should be carried out other than where this would mean unnecessary delay (B, III).
- The treatment of locoregional recurrence in a limb is palliative. Initial treatment is usually surgical, followed, where necessary, by carbon dioxide laser treatment and possibly isolated limb perfusion (B, II).

Occult Primary Melanoma

Patients with occult primary melanoma will present with lymph node disease, a single soft-tissue metastasis, or systemic disease in the absence of a recognizable primary. The presenting lymph nodes or systemic metastases should be treated appropriately regardless of the inability to detect the primary lesion (III).

Metastatic Disease

All patients should have access to a palliative care team providing expertise in symptom control and psychosocial support. Links should be made with community cancer support networks as soon as possible.

Recommendations for Metastatic Disease

- Consideration of surgically resectable metastases should be made, such as in the skin, brain, or gut (B, II).
- Radiotherapy may have a palliative role in the treatment of metastases (B, II).
- The standard chemotherapy of choice is dacarbazine although its role is palliative (C, II).

Melanoma, Hormone Replacement Therapy, and Pregnancy

There is no evidence that melanoma at or near the time of pregnancy adversely affects the prognosis, but the data are limited. The Breslow thickness, site, and presence of ulceration are still the key determinants (III).

Advice about continuance of and future pregnancies should be given based on the patient's prognosis and the possible social consequences of it; that is, the relative chance that a mother might die when her child was young, compared with that of a woman of the same age without melanoma. These social or family considerations may also be relevant to a male patient whose partner is pregnant or if he and his partner are considering a pregnancy.

Recommendations for Hormone Replacement Therapy and Pregnancy

- There are no data contraindicating the use of the contraceptive pill or hormone replacement therapy after melanoma (B, II).
- The risk of subsequent pregnancy on outcome from melanoma is not known.

Follow-up

All patients should be taught self-examination because many recurrences are found by patients themselves at home rather than by clinicians in the clinic.

The following should be examined and details recorded at each follow-up: site of primary and adjacent skin, for local recurrences and local metastatic disease; the draining lymph node basins, for lymphadenopathy; the remaining skin, for any other suspicious pigmented lesion. Regular radiological imaging is currently not a necessity but clinical photography may be helpful in follow-up, particularly in those with multiple atypical moles.

Recommendations for Follow-up

- Patients with in situ melanomas do not require follow-up.
- Patients with invasive melanomas should be followed up 3-monthly for 3 years. Where the melanoma thickness was less than 1 mm, the patient may be discharged; others should be followed up for a further 2 years at 6-monthly intervals.

  (C)

Definitions:

Levels of Evidence

Ia: Evidence obtained from meta-analysis of randomized controlled trials

Ib: Evidence obtained from at least one randomized controlled trial

IIa: Evidence obtained from at least one well-designed controlled study without randomization

IIb: Evidence obtained from at least one other type of well-designed quasi-experimental study

III: Evidence obtained from well-designed non-experimental descriptive studies, such as comparative studies, correlation studies, and case studies

IV: Evidence obtained from expert committee reports or opinions and/or clinical experience of respected authorities

Grades of Recommendations

A. There is good evidence to support the use of the procedure.
B. There is fair evidence to support the use of the procedure.
C. There is poor evidence to support the use of the procedure.
D. There is fair evidence to support the rejection of the use of the procedure.
E. There is good evidence to support the rejection of the use of the procedure.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

The type of supporting evidence is identified and graded for selected recommendations (see "Major Recommendations").

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Consistent high quality treatment for patients with cutaneous melanoma

POTENTIAL HARMS

Side effects of treatment

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

- These guidelines reflect the best data available at the time the report was prepared. Caution should be exercised in interpreting the data; the results of future studies may require alteration of the conclusions or recommendations in this report. It may be necessary or even desirable to depart from the guidelines in the interests of specific patients and special circumstances. Just as adherence to the guidelines may not constitute defence against a claim of negligence, so deviation from them should not necessarily be deemed negligent.
- It is important that these guidelines are used appropriately in that they can only assist the practitioner and cannot be used to mandate, authorise, or outlaw treatment options. Of course it is the responsibility of the practising clinician to interpret the application of guidelines, taking into account local circumstances.
- Guidelines are inherently a fluid, dynamic process and will be updated on the British Association of Dermatologists (BAD) Web site on a regular basis.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Possible Audit Points

- What proportion of lesions had incisional rather than excisional biopsy?
- What proportion of melanomas was seen within 2 weeks of referral?

If melanomas have been excised in general practice but not referred:

- Audit completeness of clinical and/or pathology data recording compared with the guideline's dataset.
- Audit treatment modalities used for lentigo maligna melanoma.
- Have patients had appropriate investigations according to stage of melanoma, and what are the results for each investigation?
- Have eligible patients been counselled about clinical trials, and what proportion has been entered?
- For patients entering clinical trials, have entry criteria been fulfilled (e.g., adequate number of lymph nodes examined pathologically after a block dissection)?

IMPLEMENTATION TOOLS

Audit Criteria/Indicators

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness
Staying Healthy

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Roberts DL, Anstey AV, Barlow RJ, Cox NH, Newton Bishop JA, Corrie PG, Evans J, Gore ME, Hall PN, Kirkham N. U.K. guidelines for the management of cutaneous melanoma. Br J Dermatol 2002 Jan;146(1):7-17. [60 references] PubMed

ADAPTATION

Not applicable: The guideline was not adapted from another source.

DATE RELEASED

2002 Jan

GUIDELINE DEVELOPER(S)

British Association of Dermatologists

SOURCE(S) OF FUNDING

British Association of Dermatologists

GUIDELINE COMMITTEE

British Association of Dermatologists Therapy Guidelines and Audit Subcommittee

The Multiprofessional Skin Cancer Committee

COMPOSITION OF GROUP THAT AUTHORED THE GUIDELINE

Primary Authors: D.L.L. Roberts, Singleton Hospital, Swansea, UK; A.V. Anstey, Royal Gwent Hospital, Newport, UK; R.J. Barlow, St John's Institute of Dermatology, St Thomas' Hospital, London, UK; N.H. Cox, Department of Dermatology, Cumberland Infirmary, Carlisle, UK; J.A. Newton Bishop, Genetic Epidemiology Division, ICRF Clinical Centre in Leeds, Cancer Genetics Building, St James's University Hospital, Leeds, UK; P.G. Corrie, Addenbrooke's Hospital, Cambridge, UK; J. Evans, Nuffield Hospital, Plymouth, UK; M.E. Gore, Royal Marsden Hospital, London, UK; P.N. Hall, Addenbrooke's Hospital, Cambridge, UK;

N. Kirkham, Department of Histopathology, Royal Sussex County Hospital, Brighton, UK

British Association of Dermatologists Therapy Guidelines and Audit Committee Members: N.H. Cox (Chairman); A.V. Anstey; C.B. Bunker; M.J.D. Goodfield; A.S. Highet; D. Mehta; R.H. Meyrick Thomas; J.K. Schofield

The Multiprofessional Skin Cancer Committee Members: N.H. Cox (Chairman); A.Y. Finlay; B.R. Allen; D. Murray; R.W. Griffiths; A. Batchelor; D. Morgan; J.K. Schofield; C.B. Bunker; N.R. Telfer; G.B. Colver; P.W. Bowers; and the authors.

FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

ENDORSER(S)

Royal College of General Practitioners - Medical Specialty Society
Royal College of Pathologists - Medical Specialty Society
Royal College of Physicians - Medical Specialty Society
Royal College of Radiologists - Medical Specialty Society
Royal College of Surgeons of Edinburgh - Medical Specialty Society
Royal College of Surgeons of England - Medical Specialty Society

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site.

AVAILABILITY OF COMPANION DOCUMENTS

The following is available:

- Griffiths CE. The British Association of Dermatologists guidelines for the management of skin disease Br J Dermatol. 1999 Sep;141(3):396-7.

Electronic copies: Available in Portable Document Format (PDF) from the British Association of Dermatologists Web site.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on April 22, 2005. The information was verified by the guideline developer on June 27, 2005.

COPYRIGHT STATEMENT

DISCLAIMER

NGC DISCLAIMER

The National Guideline Clearinghouse™ (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the NGC Inclusion Criteria which may be found at http://www.guideline.gov/about/inclusion.aspx.

NGC, AHRQ, and its contractor ECRI make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.

Date Modified: 9/25/2006